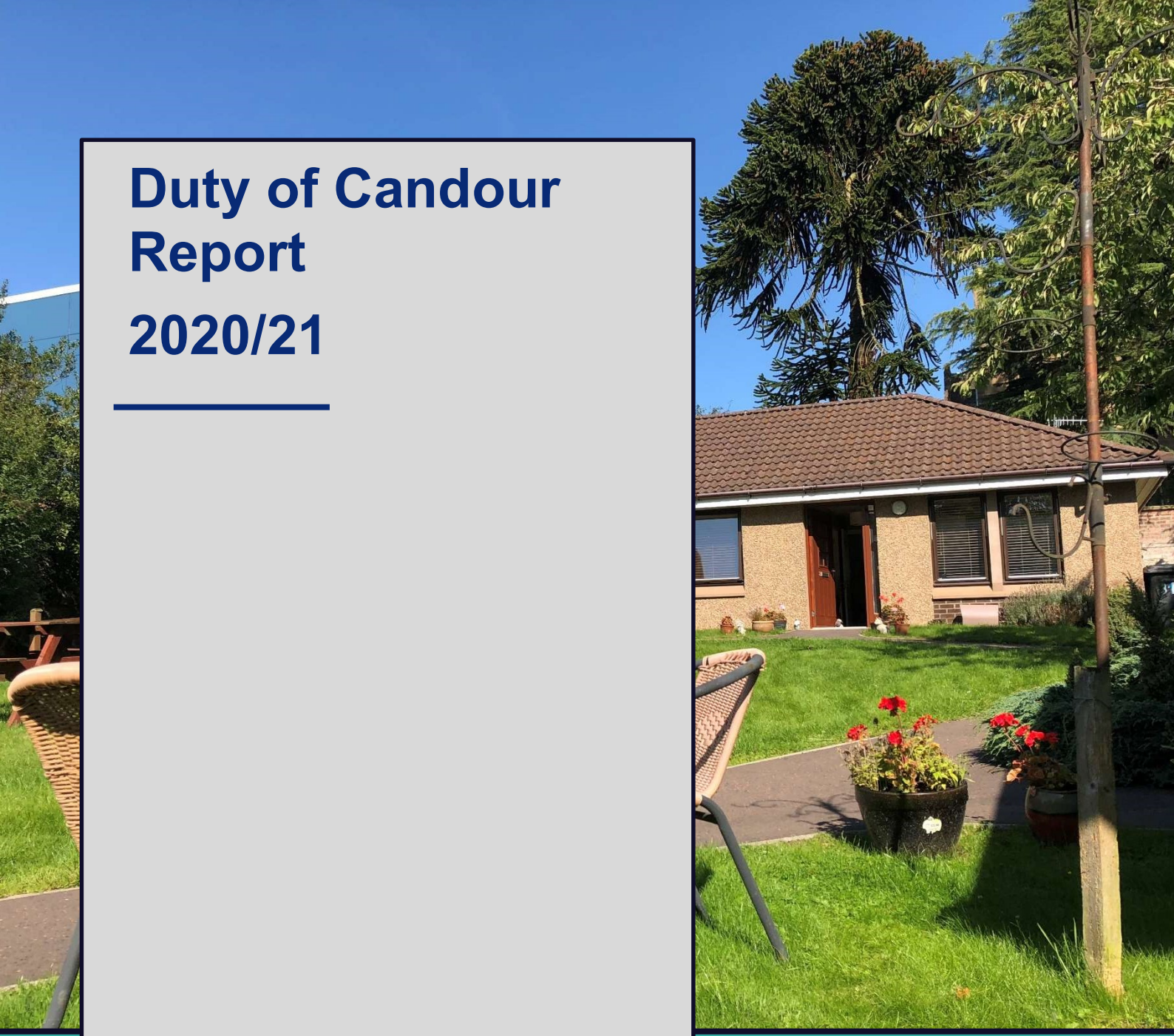

Duty of Candour Report 2020/21

APRIL 2021

Eildon Housing Association
The Weaving Shed
Ettrick Mill
Dunsdale Road
Selkirk TD7 5EB

EILDON HOUSING
Caring, Committed, Connected, Creative

Eildon Housing Association Duty of Candour Report

Duty of Candour

The Duty of Candour is the obligation for any registered service to be open and transparent when there has been an unintended or unexpected incident that results in death or harm (or treatment is required to prevent death or harm). There is a legal requirement to ensure that when things go wrong the affected people are offered an explanation, an apology, and assurances that lessons will be learned from the error.

Reporting on Duty of Candour is incorporated into our Statutory Reporting Procedure which underpins our approach to monitoring and reporting across our care services.

About Eildon

Eildon Housing Association provides housing, care, and support services to people across the Scottish Borders – serving nearly 50 communities in Borders towns, villages, and rural areas.

All staff working in our care services undertake training on Duty of Candour through our Learning Management System online, and our induction process includes our policies and procedures for Incident Reporting. In the event of incidents which may trigger Duty of Candour reporting requirements (or are otherwise significant) we offer additional support to staff, to reflect and debrief, and external counselling and support is also available to all staff through Westfield Health.

As an organisation, we are committed to transparency, continuous improvement, and the professional development of our staff teams.

Period April 2020 – March 2021

All Health and Social Care Services across Scotland must provide an annual Duty of Candour report. This report will note any instances where Duty of Candour has been triggered within the reporting period, describe the actions taken as a result of the incident and outline the lessons learned and how these lessons will be incorporated into our daily practice.

Between the reporting period of April 2020 to March 2021, there were no incidents which met the criteria for Duty of Candour reporting.

Type of unexpected or unintended incident, and number of times this incident type occurred across our care services

Someone has died	0
Someone has permanently lost bodily, sensory, motor, physiologic or intellectual functions	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor, or intellectual function is impaired for 28 days or more	0
Someone experienced pain or psychological harm for 28 days or more	0
A person needed health treatment to prevent them dying	0
A person needed health treatment to prevent other injuries	0

All incidents, accidents, and errors are recorded, discussed, and analysed as part of the operational management of our services. Actions taken as a result are noted and reported to our regulators and commissioners as appropriate.

During the reporting period, there were other notifiable events which did not meet the criteria for Duty of Candour reporting. We have reviewed each event and taken appropriate actions identified. We have also reviewed our care practices to ensure we incorporate any learning from these events into our service delivery.

We have continued to closely monitor the impact of Covid-19 on our services, reviewing guidance and seeking clarification from the Care Inspectorate and public health regarding incidents as they arise because of the Covid-19 pandemic. No Duty of Candour triggers were identified.

Learning From Notifiable Events

For each notifiable event we consider any steps that should be taken to minimise the likelihood of the event recurring, either within the same service, or elsewhere in our organisation. Where actions are identified, we aim to communicate with affected people what we are doing and why, to demonstrate transparency and reflective practice.

We also discuss all serious medication-related incidents within our Senior Team regularly and agree any changes to our practice that may be needed in response to these. Where proportionate, this would also involve discussion with the wider Housing and Care Management Team.

All non-notifiable incidents and errors are also discussed within the service to identify potential causes or patterns and, again, take any required action. This may include additional support from external partners such as Adult Social Work, or referral on to other Health services.

Learning from these discussions is then shared widely across our other teams and embedded into our approach through procedure review and staff development.